FAMILY COURT OF AUSTRALIA

RE: SALLY (SPECIAL MEDICAL PROCEDURE) ***[2010] FamCA 237***

FAMILY LAW – CHILDREN - Special Medical Procedure

Evidence Act 1995 (Cth)
Family Law Act 1975 (Cth)
Family Law Rules 2004 (Cth)

Minister for Immigration and Multicultural and Indigenous Affairs v B and Another (2004) 219 CLR 365
Re Alex; Hormonal Treatment for Gender Identity Dysphoria (2004) FLC 93-175
Re Alex [2009] FamCA 1292
State of Queensland v B [2008] QSC 231
State of Queensland v Nolan [2002] 1 Qd R 454

APPLICANT:	The Hospital
RESPONDENT:	The Mother and the Father
FRIEND OF THE COURT:	Department of Communities (Child Safety Services)

FILE NUMBER: By Court Order File Number is suppressed

DATE DELIVERED:	22 March 2010
JUDGMENT OF:	Murphy J
HEARING DATE:	22 March 2010

REPRESENTATION

By Court order the names of counsel and solicitors have been suppressed

ORDERS

IT IS ORDERED THAT

1. Pursuant to section 67ZC of the *Family Law Act 1975* (Cth):

    a. That the proposed surgery for the child SALLY born in 1995, being the bilateral removal of her gonads ("gonadectomy"), as outlined in the affidavits of Dr X and Dr Y, be permitted to occur and so as to give effect to same, that procedure and such further or other necessary and consequential procedures to give effect to the treatment of Sally for her condition of 5-alpha reductase deficiency (including but not limited to the cosmetic treatment as outlined in the affidavits of Dr X and Dr Y) may be authorised by the said child's parents.

    b. The written authority of the said child's said parents shall be sufficient so as to authorise all scientists, doctors and other medical practitioners to conduct all such operations and procedures as are authorised by these orders.

2. For the purposes of the publication of the judgment in this matter as authorised by section 121(9) of the Act:

    a. this matter shall be known by, and referred to as, "*Re Sally (Special Medical Procedure)*";

    b. the names of each and every doctor or scientist referred to within the judgment shall be anonymised;

    c. the names of the child's parents shall be anonymised and the child shall be referred to as "Sally";

    d. all references to any geographic locality shall be deleted; and

    e. all references to the file number, registry information and details of any representatives be suppressed.

IT IS NOTED that publication of this judgment under the pseudonym *Re Sally (Special Medical Procedure)* is approved pursuant to s 121(9)(g) of the *Family Law Act 1975* (Cth)

FAMILY COURT OF AUSTRALIA

FILE NUMBER: By Court Order File Number is suppressed

A Hospital
Applicant

And

The Mother and the Father
Respondents

EX TEMPORE
REASONS FOR JUDGMENT

1. Sally was born into a loving family in 1995. She had no health difficulties at birth and, to all intents and purposes, appeared to be a happy and healthy baby girl.

2. That remained the case until she was about 11. At that time, her mother deposes:

> … she told me that she'd found two lumps; one in the right side of her abdomen, and the other in her left labia. She asked me if they were "nuts" meaning testes. I immediately said no, but due to [Sally's] concerns, I arranged for her to see our local GP. The GP examined [Sally], and said that the lumps were a normal part of the puberty process. I thought nothing of it after that.

3. Sally's mother goes on to depose,

> When she was in grade 7, she asked me why she had not started her periods, as most of her friends at school had started to get periods. I told her that girls start to have periods [at] different times, and not to be too concerned about it. [Sally's] breast development appeared to be normal. [Sally] had also raised the concerns regarding a deepening of her voice. The deepening of [Sally's] voice had happened gradually. I had never really given it any thought; as far as I was concerned, it was [Sally].

4. In early 2009, behavioural issues manifested themselves at school. Ultimately, Sally consulted a paediatrician. Initial tests revealed that Sally had XY genotype, did not have a uterus, and had gonads present in her pelvis. That initial investigation led to further specialist medical consultations, to which further reference will shortly be made.

5. Ultimately, specialist medical and psychiatric opinion aligns in recommending a surgical procedure which $14^{1}/_{2}$ year old Sally also seeks, and in which she is supported by each of her parents. That procedure is the performance of invasive and irreversible surgery; a gonadectomy, which would see removal of her gonads, and, thus, all vestiges of her, as it were, "maleness."

6. Orders are applied for by the Hospital who would have responsibility for those doctors who would perform the mooted operation. That hospital applies for orders, relevantly, that the proposed surgery, involving the bilateral removal of her gonads, be authorised by her parents and that this authorisation operate as all such authority as is needed at law, by which to perform that operation.

Parties and Evidence

7. In accordance with the Family Law Rules (2004), applicable in cases of this type, the Department of Communities was served. Mr G appears as counsel for the Department, pursuant to leave given by me for him, to do so. The Department does not advocate for a position but appears as a friend of the Court.

8. As I have earlier said, it is plain, from affidavits filed by each of Sally's parents, that they, too, support the application. Material has been filed - not only by each of the parents, but from Dr H, who is a specialist physician practicing as a paediatric endocrinologist; Dr T, who is a paediatric psychiatrist; Dr X, who is a paediatric surgeon; and Dr L, who is the specialist to whom Sally was first referred.

9. At the outset of these proceedings, I gave leave to the applicant to rely upon an affidavit by Sally herself. As I said at the time, section 100(B) of the Act provides a specific prohibition against the use of affidavit evidence by children, save as permission is granted by a court. That section can be seen as the specific application of more general considerations, designed to prevent children being, as it were, caught in the middle of their parent's disputes., and being used as "pawns," for example, in conflicted accounts about what they might wish.

10. That a prohibition of that type might exist is, in my respectful view, unsurprising. Moreover, that such a prohibition might exist is entirely consistent with the relatively recent amendments made to the Act in Division 12(A) which, among other things, imposes mandatory duties upon the court in and about the manner in which parenting applications are dealt with.

11. In parenting proceedings before this court, the voices of children need to be, and should be, heard. That is usually done in a manner designed to itself be consistent with their best interests by involving them only to the extent that they speak to trained professionals who can be used to not only ascertain

matters directly relevant to their best interests, but can, it is hoped, be trusted to ensure that the process itself does not become harmful to the children.

12. In that respect, this court's Practice Direction relating to matters of this type, specifies that the court should consider whether an independent children's lawyer should be appointed. Mr G submits that it is unnecessary in this case, by reference to the matters that have been comprehensively dealt with in the affidavits sworn and filed by medical practitioners.

13. So too, it is unnecessary because I have determined to permit Sally to file her own affidavit, for the purposes of these proceedings.

14. I have done so because this case is clearly distinguishable from those sorts of cases where parents might seek to manipulate the views of their children to their own advantage. So too, this case is plainly distinguishable from the sort of case where the involvement of the child herself might be seen to be harmful to her.

15. I should say I am acutely aware of the fact that Sally is only 14½, nevertheless, all of the evidence before me suggests that she is a thoughtful child, lovingly cared for by her parents, who have at all times sought to discuss with her - as it seems to me, appropriately and carefully - all of the issues present for her in the dilemma which she currently confronts.

16. In those circumstances, it seems to me important to hear directly Sally's voice in these proceedings. It is for that reason that I determined to receive her affidavit.

17. And it is for that reason, that I commence the succeeding parts of these reasons by referring to her words.

Sally's Position

18. Sally gives a thoughtful and age-appropriate account of the position which she confronts. In evidence which I consider poignant and important, Sally says this:

> It hurts sometimes, knowing I have this condition. Sometimes I blame myself, because I feel like I am not normal. Sometimes I get angry, even though I know why and how it happened. I get a bit frustrated, because my mum always blames herself, but I keep telling her it's not her fault. It's just something that happened. The doctors have told me that if the gonads would remove, it would completely stop any further male development. This is what I want.

19. Sally goes on to say:

> When I was told what the lumps were, and that they were gonads, the first thing I thought of was that they could get rid of them. I want the gonads removed now, rather than wait until I am 18, as I want to start living my

> life now. I feel that once the gonads are removed, then I can get on with my life and accept my condition. I want to put the issue of the removal of the gonads behind me, and I can only do this if the gonads are removed.
>
> …
>
> I know that after the gonads are removed, I might have to have more surgery for my vagina. Dr [X] has told me that he does not want to go to more surgery, because it might wreck sensation. He said that I would only have surgery if all else fails. If I needed surgery to look more like a normal female, I would want to have it. I know I can never have babies, but I want to be as much like a normal woman as possible. I don't know how I would feel if I could not have the gonads removed now. I do not want to think about them not being removed. I suppose I would just wait until I was 18, and then I would have them removed as soon as I could.

20. Sally's words accord with those statements made by her recorded by the various medical practitioners who have provided affidavits. They are also entirely consistent with the evidence of her parents.

21. Moreover, each of her parents depose (as does Sally) to a childhood in which she clearly has identified as a girl, and in which she has engaged in the sort of behaviour and gender identification that might be expected of a girl of her age.

22. I should, perhaps, before going further, refer briefly to issues of jurisdiction, power and locus standi.

Jurisdiction and Power

23. Both parties contend that the court has jurisdiction to hear and determine this matter. As was submitted by Mr G, this court's jurisdiction to hear matters of this type was, perhaps, clearer prior to the decision of the High Court in *Minister for Immigration and Multicultural and Indigenous Affairs v B and Another* (2004) 219 CLR 365.

24. That decision might be seen to make the issue of jurisdiction in cases of this type somewhat more cloudy; however, I note that, for present purposes at least, Gleeson CJ and McHugh J said at paragraph 52 of their Honour's joint judgment:

> By necessary implication, the Family Court may also make an order under section 67ZC that is binding on a parent under that section. It may also make orders such as those made in Marion's case or those analogous to orders traditionally made by courts exercising the parent's patriae jurisdiction …

25. Ms F, counsel for the applicant, goes on to submit in written submissions that the court has jurisdiction for these reasons:

(a) the orders sought are not directed to third parties but to the parents of the child who is the child of the marriage;

(b) the orders sought are analogous to those traditionally made under the parens patriae jurisdiction and;

(c) the orders sought are similar to those made in Marion's case, in that technically they relate to the sterilisation of a child.

26. I am content, in the absence of submissions made to the contrary, to assume on the basis of the arguments presented by each of the counsel in this case that the court has jurisdiction and power to make the orders sought.

Locus Standi

27. Similar consideration applies to the standing of the applicant. Ms F refers to the decision of the Supreme Court of Queensland in the *State of Queensland v B* [2008] QSC 231. There Wilson J, referred to, and agreed with, an earlier decision of Chesterman J in the *State of Queensland v Nolan* [2002] 1 Qd R 454. Each was referenced to section 286 of the *Criminal Code* (Qld) which provides, relevantly, that "a person who has care of a child" includes a number of particular people there specified.

28. The court found that the Code definition was capable of extending to a hospital and doctors who have undertaken the care of a child (in a context relevant to those Supreme Court decisions). Ms F argues that those decisions give weight to the applicant being a person "concerned with the care, welfare or development of the child" within the meaning of section 69C(2)(d) of the Act.

29. Mr G, in written submissions, submits that:

> The operation will be performed in premises operated by, and presumably by doctors and health professionals who are under the control of, and/or for whom, the applicant will be legally responsible. Previous applications of this type have been made by health bodies and the standing of such applicants does not appear to be doubted.

30. Again, I am content to proceed on the assumption which, in any event, I consider to be correct, that the applicant is a person "concerned with the care, welfare or development of the child" the subject of these proceedings and to hold, accordingly, that it has standing to seek the orders which it does.

Sally's Best Interests: Risks, Benefits and Other Matters

31. The nature of the condition from which Sally suffers is 5-alpha-reductase deficiency. It is an extremely rare condition and affects only genetic males. Sally, despite identifying as a female for the whole of her life, is in fact a genetic male.

32. As evidence of the rarity of this condition, a person whom Dr H says is an acknowledged expert in Australia in disorders of sexual development (Professor R) tells her that he has seen in his career only one patient with this condition and that was a child from overseas.

33. Dr H describes in her affidavit what needs to be done, "in order [for [Sally]] to live more normally as a female." The treatment involves:

    (a) removal of her testes to prevent any further testosterone production and to remove the obvious swellings in her labia and inguinal region;

    (b) the potential need for surgery to reduce the size of her clitoris;

    (c) treatment (which may also involve surgery) to enlarge the size of her vagina prior to sexual activity; and

    (d) ongoing oestrogen supplements for the remainder of her life.

34. From Dr H's perspective the reasons for removing Sally's testicular tissue are as follows:

    (a) Sally identifies as being female and it would therefore not be of benefit for her to have testicular tissue;

    (b) without pubertal suppression the testes will make testosterone and cause further virilisation (for example, more voice changes, greater enlargement of the clitoris); and

    (c) the testes are causing large swellings in her left labia and right inguinal region. These would potentially be visible, particularly if, for example, Sally were wearing underwear or swimwear.

35. The latter are matters that are referred to both by Sally and her mother as matters which cause Sally some present distress.

36. An important consideration for this court in deciding whether the mooted surgery is in the best interests of Sally is, as it seems to me, satisfaction that Sally is not suffering from a gender identity disorder as that term is described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The reason for that is that, if such a condition was present in Sally, the underlying issue for her would be one of psychology, as distinct from, perhaps, a condition involving invasive and irreversible medical procedure.

37. Unsurprisingly in the context of this case, Sally was referred to a paediatric psychiatrist, Dr T. Dr T is firmly of the view that Sally does not suffer from gender identity disorder. Moreover, Dr T is of the view, having seen and spoken to Sally now on a number of occasions, detailed in his affidavit, that Sally identifies as a female and clearly sees herself as a girl. He opines that Sally has "no clinical signs of gender identity disorder."

38. When specifically asked how she felt about her body, Sally told Dr T that she was comfortable with it but "does not want to be a girl with balls." She has never expressed the desire to be a boy.

39. Present in Dr T's affidavit, and in the affidavits of other medical practitioners, Sally's parents and the affidavit of Sally herself, is an ongoing concern with the fact that her voice has deepened, consistent with pubertal changes that might occur in a male. This has caused her significant embarrassment and, on at least a couple of occasions, has resulted in "bullying type" behaviour that has caused her distress.

40. If Sally is to have an invasive and irreversible medical procedure then the court ought be satisfied that the risk of her changing her mind as she matures and grows, both psychologically and physically, is such as to not present for Sally the awful prospect of having to go through such a procedure only to, as it were, later regret it.

41. I accept the submission effectively made by each counsel that, taking the evidence as a whole, this risk is low, even taking account of the fact that Sally is only 14½.

42. I have already referred to some, at least, of the evidence relating to Sally's clear identification of herself as a female. I consider it important to refer to the evidence of Dr T. In my view, Dr T has not only arrived at the conclusion just expressed by reference to a careful analysis, apparent in his affidavit, of what Sally has told him, but has, importantly, also considered alternative hypotheses. Dr T says this:

> A number of papers have reported about gender identity in XY intersexuality, in particular, 5-alpha-RD. It should be emphasised that the disorder is rare and many of the published papers are based on small numbers of case reviews. Many of the papers have noted a gender role change after puberty in individuals with 5-alpha-RDsa who are raised as girls, with as high as 56-63 later changing their gender identity to that of a male over the course of adolescence and early adulthood.
>
> While this may be the case, I wish to make the following points:
>
> (a) Most of the literature reports on individuals in developing countries who did not have the opportunity for treatment;
>
> (b) significant numbers (37-46 per cent) of individuals retained their female identity, many of whom were untreated.

43. I should also refer in that respect to other evidence before me that suggests that, in the very small samples in which that phenomena was noticed, there may be significant cultural issues attaching - for example to the importance or dominance of male sexuality within the culture - that might explain the desire to later change from female to male identity.

44. Dr T goes on to say:

> From reading the literature it is my understanding that the vast majority of individuals with 5 ARD who changed their gender identity did so following puberty when they were subjected to increased testosterone, in other words very few reported gender dysphoria during their early childhood. [Sally] is currently treated with lucrin in which all testosterone production is ceased. It would be difficult to argue that it would be in [Sally's] best interest for this treatment [to be] ceased over adolescence in order to observe if this leads to any demonstrable change in her gender identity.

45. The proposed procedure, of course, comes with some risks. The physical risks are described by the paediatric surgeon Dr X and also Dr H. Broadly described, the risks associated with the procedure itself (which as, Mr G submitted, would appear to be conducted predominately if not wholly by keyhole) might be broadly described as those associated with any surgical procedure.

46. There are, understandably enough, also potential psychological side effects associated with the procedure which Dr T has identified. They include:

    (a) Issues of identity. How she, as an adolescent or young adult, will adjust to the knowledge that she is unable to have children and pass on her "genetic imprint".

    (b) Adjustment to the fact that while she appears as a female she actually has a Y chromosome and is therefore genetically a male.

    (c) The likelihood that Sally does not have a uterus or other internal female organs and has a shortened or blunted vagina.

47. All these issues may raise questions in Sally's mind about her sexuality and places her at an increased risk of mental health problems during adolescence and beyond. Plainly then, as Dr T identifies there are psychological risks associated with the procedure.

48. However, Dr T also carefully analyses and enumerates what, in his opinion, is "the risk of psychiatric harm" if the operation was not to be performed. Dr T is of the view that psychiatric harm "would be exacerbated" for the following reasons:

    (a) … [Sally] has a fixed female gender identity and sees the presence of gonads and the risk of further masculinisation as extremely distressing. She sees the gonadectomy as a procedure which will allow her to move on with a normal life.

    (b) The continued presence of the gonads would inhibit her ability to develop normal sexual relationships. The lump in her labia is visible and palpable and would no doubt have an impact on her

sexual partners which would embarrass [Sally] and which she may find it difficult to explain.

(c) Denial of the opportunity to undergo gonadectomy in the short term may result in [Sally] externalising her anger towards the legal profession, the medical professional, her family and herself. This is a particular risk with [Sally] who has already demonstrated that she has some oppositional or defiant traits in her personality.

49. Mr G submits, by reference to the decision of the former Chief Justice Nicholson in *Re Alex; Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC93-175 that I ought pay particular attention whether the application in the present case can be seen as being "necessary".

50. In that respect, there are signs within the material, as I have indicated, that Sally is a mature young woman who has carefully and thoughtfully considered the issues relevant to this application in consultation with her parents and her medical practitioners. She would appear to understand the reasons why the procedure is recommended and also appears to understand that there might be risks associated with it, in both the physical and psychological sense.

51. Mr G submits that, notwithstanding these indications of "Gillick competence", this court would nevertheless require a very firm foundation before arriving at a conclusion that a 14½ year old child was Gillick competent for the purposes of authorising a procedure as significant as this. I agree with that submission.

52. When the ramifications of the procedure are taken into account, including, of course, its irreversibility in particular, and the potential ramifications which it might have on Sally's psychological health, both currently and in the future, I would be extremely reluctant to proceed on the basis that she is Gillick competent.

53. In my view the application to this court is necessary in the sense in which that expression is used by the former chief justice in *Re Alex; Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC93-175.

54. Another matter directly concerned with whether the proposed treatment ought be authorised in Sally's best interests is the fact that an alternative is available.

55. It is possible for the procedure to be postponed until such time as Sally is legally competent, which, it might be noted, is only some 3½ years away. I say "only" by reference to the chronological timeframe involved. But, for a child of 14½, who has endured, and is likely to continue to endure, matters which cause her very significant embarrassment and concern, I suspect that 3½ years is likely to seem much, much longer than that.

56. Moreover there is, in any event, some significant risks associated with the postponement of the procedure.

57. Firstly, I agree, with respect, with Dr T that it would be difficult to argue that it would be in Sally's best interests in that intervening time to cease the current treatment which suppresses testosterone, so as to ascertain whether this young woman, who has always identified as a female, should feel differently in those circumstances.

58. I would add, as would appear to be said "between the lines" by Dr T, that I very much doubt whether doing so would be ethically appropriate for any medical practitioner given the other evidence about Sally's current psychological and physical status.

59. Further, Dr X is quite specific in his opinion that Sally should undergo a gonadectomy "in the short term". The doctor considers that to be best for both Sally's physical and mental welfare. He says:

> Leaving the gonads in situ will increase the risk of malignancy, in fact if a male patient in his teens presented to me with testes in the abdomen, in all likelihood I would recommend their removal. [Sally] will need a laparoscopy for diagnostic purposes in any event. Postponing the gonadectomy would result in [Sally] having to undergo two surgical procedures with their associated risks and discomfort instead of one. Continuing with hormonal treatment alone leaves the risks that if for any reason that treatment is interrupted, [Sally] would experience further virilisation and increased masculinity in [Sally's] appearance. The experience of further virilisation or masculinisation would doubtless have emotional and psychological impacts upon [Sally].

60. Puberty is of itself difficult for children who are becoming young adults to deal with. As is widely known (as to which see s 140 of the *Evidence Act* (Cth) 1995) it is a time pregnant with all sorts of difficulties including significant difficulties in and about relationships with peers, with parents and with other adult or authority figures.

61. Sally has, by reason of being pubescent alone, a significant number of things to deal with. It is also evident on the material that she is not fond of school and is desirous of leaving and there have been some behavioural difficulties experienced by her whilst at school. Medical opinion seems to be that these difficulties pre-dated the concerns with which I am concerned, but the onset of puberty may have exacerbated those particular concerns.

62. Sally clearly identifies a number of things that are causing her concern at a time in her life when things such as comfort with her own body, relationships with friends, members of the opposite sex and the like are in any event important to her and which the matters identified by her make markedly more difficult.

63. In that respect I note the evidence of each of her parents who, on any view of it, have been loving, caring and supportive of Sally. The Father says for example, that he believes that Sally's condition:

> Has affected her self esteem and will continue to do so until she has the proposed surgery. I think the proposed surgery will alleviate some frustration and anxiety for [Sally].

64. I have made during the course of these ex tempore reasons, reference to the expression "best interests".

65. Both Mr G and Ms F submit that the decision in this case is governed by best interest considerations and that is plainly right. Mr G points out that, in *Re Alex* [2009] FamCA 1292 Bryant CJ said that because a decision made pursuant to s 67ZC comes within part VII of the Act and is therefore a "child related matter" the Considerations set forth in section 60CC (a section entitled "How a court determines what is in a child's best interests") must be applied. Insofar as they are relevant to the situation confronting the court here, with respect that too is correct.

66. Having said that, it is plainly not necessary in my view for a court to seriatim address each and every one of those matters. That is all the more so where it is plain by reference to the particular circumstances of the case that the considerations there enunciated, together with the principles and objects otherwise outlined in the Act, have been uppermost in the court's mind.

67. Of course, cases of this type might, in any event, be thought to not find ready reflection in those Considerations, Objects and Principles, given that those mandatory statutory matters are more usually applicable to circumstances in which parents and other persons concerned with the welfare of a child, are in conflict about parenting orders that will reflect the best interests of that child.

68. Nevertheless, I make it plain in these reasons that I have taken account of, in particular, the likely effect of any changes in Sally's circumstances. Plainly enough, the surgery will involve significant changes of one sort or another. I have earlier outlined the possible benefits and detriments of those changes as referred to by the treating medical practitioners and I have concluded that the likely effect of the changes brought about by the prospective surgery are more likely to be in Sally's best interests than if the surgery does not occur.

69. So, too, a requirement to take into account, if relevant, the "sex" of the child and "any other characteristics of the child" are plainly germane to the issues before me and again, I have taken account of the matters that I consider to be relevant to those Considerations in arriving at my decision.

70. Other matters already addressed which might include, for example, the risks of surgery (and the risks of not having surgery) whether physical or psychological, are also addressed by me by reference to s 60CC(3)(m) as other facts or circumstances which, to my mind, are particularly relevant to the circumstances of this case.

71. Despite the fact that all parties are in agreement about a proposed course of action, and those who agree include the child, the parents and the relevant medical agency, this court nevertheless retains an independent obligation to consider all of the matters directly relevant to Sally's best interests in arriving at a conclusion about whether this invasive and irreversible procedure ought be permitted.

72. In my view, all of the evidence points clearly and unequivocally to a conclusion that Sally being permitted to undergo that procedure is in her best interests and I propose to so order.

73. The terms of the orders that I make are broadly consistent with those sought in the application by the agency and I will frame those orders at the time of the delivery of the perfected version of these reasons.

I certify that the preceding seventy-three (73) paragraphs are a true copy of the reasons for judgment of the Honourable Justice Murphy

Associate:

Date: 24 March 2010